

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0012765</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Pinecrest Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/02</u> to <u>6/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>414 S. Wesley Avenue</u> <u>Mount Morris</u> <u>61054</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Ogle</u>		(Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>( 815 ) 734-4103</u> <b>Fax #</b> <u>( 815 ) 734-7131</u>		(Type or Print Name) _____	
<b>IDPA ID Number:</b> <u>362181961001</u>		(Title) _____	
<b>Date of Initial License for Current Owners:</b> <u>06/27/63</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
<b>Type of Ownership:</b>		(Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>(312) 634-3400</u> <b>Fax #</b> <u>(312) 634-5518</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>IRS Exemption Code</b> <u>501(c)(3)</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Christine A. Hanover</u> <b>Telephone Number:</b> <u>( 312 ) 634-3400</u> <b>Please send copies of desk review and audit adjustments to address on this page</b>			

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Pinecrest Manor# 0012765 Report Period Beginning: 07/01/02 Ending: 6/30/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 3/3/2003

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,885</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>94</u>	<u>34,555</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>144</u>	TOTALS	<u>143</u>	<u>52,440</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,175</u>	<u>6,293</u>	<u>2,690</u>	<u>15,158</u>	8
9	SNF/PED					9
10	ICF	<u>16,423</u>	<u>15,738</u>		<u>32,161</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,598</u>	<u>22,031</u>	<u>2,690</u>	<u>47,319</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 90.23%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 6/27/63

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date \_\_\_\_\_

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 49 and days of care provided 2,690Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 6/30/03 Fiscal Year: 6/30/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Pinecrest Manor

# 0012765

Report Period Beginning:

07/01/02

Ending:

6/30/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	370,966	21,131	3,661	395,758		395,758	(63,558)	332,200			1
2	Food Purchase		384,608		384,608		384,608	(105,763)	278,845			2
3	Housekeeping	166,337	39,369	5,655	211,361		211,361	(31,356)	180,005			3
4	Laundry	112,188	15,979		128,167		128,167	(4,215)	123,952			4
5	Heat and Other Utilities			196,230	196,230		196,230		196,230			5
6	Maintenance	175,358	11,247	101,785	288,390		288,390	(53,431)	234,959			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	824,849	472,334	307,331	1,604,514		1,604,514	(258,323)	1,346,191			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			17,769	17,769		17,769		17,769			9
10	Nursing and Medical Records	2,721,889	90,400	195,685	3,007,974		3,007,974	(17,662)	2,990,312			10
10a	Therapy			278,728	278,728		278,728		278,728			10a
11	Activities	128,810	12,456	2,378	143,644		143,644	(1,563)	142,081			11
12	Social Services	82,531		474	83,005		83,005		83,005			12
13	Nurse Aide Training			4,910	4,910		4,910		4,910			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,933,230	102,856	499,944	3,536,030		3,536,030	(19,225)	3,516,805			16
	<b>C. General Administration</b>											
17	Administrative	67,446			67,446		67,446		67,446			17
18	Directors Fees											18
19	Professional Services			76,190	76,190		76,190	(303)	75,887			19
20	Dues, Fees, Subscriptions & Promotions			15,564	15,564		15,564		15,564			20
21	Clerical & General Office Expenses	221,631	30,855	52,272	304,758		304,758	(90,253)	214,505			21
22	Employee Benefits & Payroll Taxes			824,899	824,899		824,899	(49,216)	775,683			22
23	Inservice Training & Education			1,691	1,691		1,691		1,691			23
24	Travel and Seminar			8,176	8,176		8,176	(210)	7,966			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,330	77,330		77,330		77,330			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	289,077	30,855	1,056,122	1,376,054		1,376,054	(139,982)	1,236,072			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,047,156	606,045	1,863,397	6,516,598		6,516,598	(417,530)	6,099,068			29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\* See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			346,494	346,494		346,494	39,133	385,627			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			163,625	163,625		163,625	(26,731)	136,894			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			510,119	510,119		510,119	12,402	522,521			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,206		80,206		80,206		80,206			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,661	78,661		78,661		78,661			42
43	Other (specify):* <b>Nonallowable Costs</b>	75,008	931	73,669	149,608		149,608	(149,608)				43
44	<b>TOTAL Special Cost Centers</b>	75,008	81,137	152,330	308,475		308,475	(149,608)	158,867			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,122,164	687,182	2,525,846	7,335,192		7,335,192	(554,736)	6,780,456			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Pinecrest Manor

# 0012765

Report Period Beginning:

07/01/02

Ending:

6/30/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(19,230)	2		4
5 Telephone, TV & Radio in Resident Rooms	(491)	21		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	39,133	30		9
10 Interest and Other Investment Income	(26,731)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(30,567)	43		24
25 Fund Raising, Advertising and Promotional	(12,251)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See attached Schedule 5A	(120,155)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (170,292)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(384,444)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (384,444)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (554,736)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Pinecrest Manor

ID# 0012765

Report Period Beginning: 07/01/02

Ending: 6/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountants' Compilation Report

**Pinecrest Manor**  
**Provider # 0012765**  
**6/30/2003**

**Schedule 5A**

Schedule VI. Part A - Adjustment Detail, Line 29

<b><u>Non-allowable expenses</u></b>	<b><u>Amount</u></b>	<b><u>Reference</u></b>
Vending income offset	(10,340)	2
Housekeeping related party wages income offset	(620)	3
Laundry related party wages income offset	(777)	4
Out of period legal fees	(303)	19
Nonallowable travel and seminar	(210)	24
Miscellaneous income offset	(1,115)	21
Developmental wages	(75,008)	43
Other developmental costs	(12,606)	43
Nonallowable trustee expense	(1,569)	43
Nonallowable publications	(5,202)	43
Nonallowable cable tv	(12,246)	43
Nonallowable professional service fees	(159)	43
Total	<u>(120,155)</u>	

**See Accountants' Compilation Report**

## Summary A

6/30/03

[illegible]

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pinecrest Manor# 0012765

Report Period Beginning:

07/01/02

Ending:

6/30/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	39,133	0	0	0	0	0	0	0	0	0	0	39,133	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,731)	0	0	0	0	0	0	0	0	0	0	(26,731)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>12,402</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,402</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(42,818)	0	0	0	0	0	0	0	0	0	0	(42,818)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(42,818)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(42,818)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(50,137)</b>	<b>(384,444)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(434,581)</b>	<b>45</b>

Facility Name & ID Number Pinecrest Manor# 0012765

Report Period Beginning:

07/01/02

Ending:

6/30/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Brethren Home	100.00%			Pinecrest Village	Mt. Morris, IL	Retirement
						Community
				Pinecrest	Mt. Morris, IL	Fund Raising
				Foundation		Foundation

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary salary	\$ 63,558	Pinecrest Village	**	\$	\$ (63,558) 1
2	V	2 Food	76,193	Pinecrest Village	**		(76,193) 2
3	V	3 Housekeeping salary	30,736	Pinecrest Village	**		(30,736) 3
4	V	4 Laundry salary	3,438	Pinecrest Village	**		(3,438) 4
5	V	6 Plant salary	53,431	Pinecrest Village	**		(53,431) 5
6	V	10 Nursing salary	17,662	Pinecrest Village	**		(17,662) 6
7	V	11 Activities salary	1,563	Pinecrest Village	**		(1,563) 7
8	V	21 Other administrative salary	88,647	Pinecrest Village	**		(88,647) 8
9	V	22 Employee benefits and payroll taxes	49,216	Pinecrest Village	**		(49,216) 9
10	V						10
11	V						11
12	V			**Pinecrest Manor and Pinecrest Village share a common Board of Directors			12
13	V						13
14	Total		\$ 384,444			\$	\$ * (384,444) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinecrest Manor # 0012765 Report Period Beginning: 07/01/02 Ending: 6/30/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	See Listing of Board of Directors Attached.								None		4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinecrest Manor # 0012765 Report Period Beginning: 07/01/02 Ending: 6/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4				N/A					4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinecrest Manor # 0012765 Report Period Beginning: 07/01/02 Ending: 6/30/03

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	American National Bank		X	Bond Issue	Interest Only	6/17/00	\$ 5,200,000	\$ 4,768,671	6/27/27	0.0458	\$ 66,140	1
2	Ameritech Credit Corporation		X	Phone System Lease	\$938.03	10/1/98	56,282		12/10/03	0.1050	995	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$938.03		\$ 5,256,282	\$ 4,768,671			\$ 67,135	9
	B. Non-Facility Related*											
10								Amortization of bond issue costs			8,119	10
11								Amortization of LOC origination fees			1,793	11
12								Letter of credit fees			86,578	12
13								Interest income offset			(26,731)	13
14	TOTAL Non-Facility Related						\$	\$			\$ 69,759	14
15	TOTALS (line 9+line14)						\$ 5,256,282	\$ 4,768,671			\$ 136,894	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Pinecrest Manor**# **0012765** Report Period Beginning: **07/01/02** Ending: **6/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																											
1. Real Estate Tax accrual used on 2002 report.		\$	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1998</td><td>8</td></tr> <tr><td>1999</td><td>9</td></tr> <tr><td>2000</td><td>10</td></tr> <tr><td>2001</td><td>11</td></tr> <tr><td>2002</td><td>N/A</td></tr> </table>	1998	8	1999	9	2000	10	2001	11	2002	N/A	<table border="1"> <tr><td colspan="2"><b>FOR OHF USE ONLY</b></td></tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1998	8																										
1999	9																										
2000	10																										
2001	11																										
2002	N/A																										
<b>FOR OHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Pinecrest Manor COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0012765

CONTACT PERSON REGARDING THIS REPORT Vernon Showalter

TELEPHONE ( 815 ) 734 - 4103 FAX #: ( 815 ) 734 - 7131

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>		\$ <u>None</u>	\$ <u>None</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

See Accountants' Compilation Report

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 79,970
 B. General Construction Type:
 Exterior
 Brick
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Pinecrest Village - Retirement Community:
 Congregate living units - 48 units; 60,413 square feet
 Independent living units - 9 units; 12,079 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 N/A
 2. Number of Years Over Which it is Being Amortized:
 N/A

3. Current Period Amortization:
 N/A
 4. Dates Incurred:
 N/A

Nature of Costs:
 N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	443,048	1889	\$ 20,626	1
2					2
3	TOTALS	443,048		\$ 20,626	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Pinecrest Manor

# 0012765

Report Period Beginning:

07/01/02

Ending:

6/30/03

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	116	1963	1963	\$ 1,248,321	\$	50	\$ 24,966	\$ 24,966	\$ 1,004,531
5		1964	1964	13,640		50	273	273	10,750
6		1965	1965	400		50	8	8	308
7		1963	1965	67,803		5-20			67,803
8		1987	1987	43,345		5-10			43,345
<b>Improvement Type**</b>									
9	Building Improvements	1965		5,475		38	144	144	5,400
10	Building Improvements	1969		3,231		15-45	58	58	2,626
11	Building Improvements	1971		9,871		5-42	203	203	7,947
12	Building Improvements	1972		4,539		10			4,539
13	Building Improvements	1973		567		5			567
14	Building Improvements	1974		130,481		5-50	2,401	2,401	81,266
15	Building Improvements	1975		17,918		10-15			17,918
16	Building Improvements	1976		22,483		5-38	505	505	22,046
17	Building Improvements	1977		12,308		10			12,308
18	Building Improvements	1978		1,354		5-10			1,354
19	Building Improvements	1979		10,885		7			10,885
20	Building Improvements	1980		6,121		5			6,121
21	Building Improvements	1981		8,640		10			8,640
22	Building Improvements	1982		54,612		5-10			54,612
23	Building Improvements	1983		65,748		5-10			65,748
24	Building Improvements	1984		74,218		5-10			74,218
25	Building Improvements	1985		28,402		5-10			28,402
26	Building Improvements	1986		53,789		5			53,789
27	Garage	1983		11,892		10			11,892
28	Brethren - House	1977		19,500		25			19,500
29	Brethren - Renovations	1980		40,698		25	1,628	1,628	38,403
30	Brethren - Insulation	1981		2,149		10			2,149
31	Brethren - Garage	1984		10,692		10			10,692
32	Brethren - Bath Remodel	1986		1,296		5			1,296
33	Brethren - Garage Improvement	1980		2,095		14			2,095
34	Energy Management	1985		3,180		10			3,180
35	Building (28 Beds)	1999		2,780,122	60,556	40	69,503	8,947	295,567
36	Carpeting	1989		805		10			805

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Pinecrest Manor

# 0012765

Report Period Beginning:

07/01/02

Ending:

6/30/03

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Canopy Extension	1987	\$ 6,935	\$	5-10	\$	\$	\$ 6,935		37
38	Entrance Way	1987	37,500	1,500	25	1,500		24,750		38
39	Building Improvements	1991	14,073		5-15			14,073		39
40	Building Improvements	1991	10,796	807	10-15	807		10,089		40
41	Capitalized Repairs	1991	1,652		10			1,652		41
42	Building Improvements	1992	5,649	474	10-20	474		5,450		42
43	Building Improvements	1992	3,071	154	10	154		3,071		43
44	Building Improvements	1992	1,380	92	15	92		966		44
45	Building Improvements	1993	3,049	151	10	151		3,049		45
46	Building Improvements	1993	28,880		5			28,880		46
47	Building Improvements	1994	4,485	224	20	224		2,128		47
48	Building Improvements	1994	621	41	15	41		390		48
49	Building Improvements	1994	14,328	955	15	955		10,029		49
50	Building Improvements	1994	14,178	945	15	945		8,978		50
51	Building Improvements	1995	630	42	15	42		357		51
52	Garage Improvements	1996	2,516		5			2,516		52
53	Blacktop Resurfacing	1996	4,902		5			4,902		53
54	Blacktop Resurfacing	1997	1,805		5			1,805		54
55	Patio doors	1997	1,285	128	10	128		832		55
56	Water softener	1997	12,260	1,226	10	1,226		7,969		56
57	Accordian door	1997	3,295	329	10	329		2,139		57
58	Roof repairs	1997	5,162	516	10	516		3,354		58
59	Furnace repairs	1997	2,358	236	10	236		1,534		59
60	Redecorating	1998	34,716	1,972	10	1,972		10,846		60
61	Countertop & wallcovering	1998	4,167	418	5	418		4,167		61
62	Door	1998	62	8	5	8		62		62
63	Paging system	1998	2,977	299	5	299		2,977		63
64	Wiring	1998	950	95	5	95		950		64
65	Asbestos Removal	1998	79,150	7,914	10	7,914		43,527		65
66	Redecorating	1999	43,753	4,375	10	4,375		19,688		66
67	Asbestos Removal	1999	17,255	1,726	10	1,726		7,767		67
68	Pipe insulation	1999	6,625	662	10	662		2,979		68
69	Landscaping	1999	8,310	831	10	831		3,739		69
70	TOTAL (lines 4 thru 69)		\$ 5,135,355	\$ 86,676		\$ 125,809	\$ 39,133	\$ 2,213,252		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**\*\*Improvement type must be detailed in order for the cost report to be considered complete**

6/30/03

**\*\*Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name &amp; ID Number Pinecrest Manor

# 0012765

Report Period Beginning:

07/01/02

Ending:

6/30/03

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,097,024	\$ 107,647	\$ 107,647	\$	5-10 Years	\$ 865,850	71
72	Current Year Purchases	87,496	6,416	6,416		5-10 Years	6,416	72
73	Fully Depreciated Assets	318,067					318,067	73
74								74
75	TOTALS	\$ 1,502,587	\$ 114,063	\$ 114,063	\$		\$ 1,190,333	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Long Term Care	94 Chevy Truck	1994	\$ 14,556	\$ 1,456	\$ 1,456	\$	10	\$ 12,376	76
77	Long Term Care	94 Dodge Van-Wheelchair	1994	22,946	2,295	2,295		10	19,507	77
78	Long Term Care	94 Dodge Van	1994	7,355	736	736		10	6,991	78
79	Long Term Care	97 Safari Van	1997	17,994	1,799	1,799		10	11,694	79
80	TOTALS			\$ 62,851	\$ 6,286	\$ 6,286	\$		\$ 50,568	80

## E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,033,121	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 346,494	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 385,627	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,133	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,007,863	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	94 - Buick - 1994	\$ 14,025	\$ 1,402	\$ 11,920	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 14,025	\$ 1,402	\$ 11,920	91

## G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

N/A

N/A

N/A

9. Option to Buy:

☐

YES

☐

NO

Terms: N/A

\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO

16. Rental Amount for movable equipment: \$

Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2004

\$

13. /2005

\$

14. /2006

\$

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input checked="" type="checkbox"/>  HOURS PER AIDE <u>40</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input checked="" type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE <u>80</u>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 4,910	\$	\$ 4,910
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 4,910	\$	\$ 4,910
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,910		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ N/A

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	<u>10</u>
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>10</b>

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1			2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
			Units of Service	Cost	Units	Cost										
					Units	Cost										
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,704	\$ 95,071	\$	1,704	\$ 95,071	1						
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		254	14,169		254	14,169	2						
3	Licensed Recreational Therapist		hrs							3						
4	Licensed Physical Therapist	L10A, C3	hrs		3,037	169,488		3,037	169,488	4						
5	Physician Care		visits							5						
6	Dental Care		visits							6						
7	Work Related Program		hrs							7						
8	Habilitation		hrs							8						
9	Pharmacy	L39, C2	# of prescripts				80,206		80,206	9						
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10						
11	Academic Education		hrs							11						
12	Exceptional Care Program									12						
13	Other (specify):									13						
14	TOTAL			\$	4,995	\$ 278,728	\$ 80,206	4,995	\$ 358,934	14						

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Pinecrest Manor

# 0012765

Report Period Beginning: 07/01/02

Ending:

6/30/03

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 29,574	\$ 29,574	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 45,000 )	621,536	621,536	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,817	76,817	6
7	Other Prepaid Expenses	63,042	63,042	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached Schedule 17A	7,388	7,388	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 798,357	\$ 798,357	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	362,750	362,750	11
12	Long-Term Investments			12
13	Land	20,626	20,626	13
14	Buildings, at Historical Cost	8,936,406	9,447,057	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,863,703	1,565,438	16
17	Accumulated Depreciation (book methods)	(3,826,056)	(4,007,863)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached Schedule 17A	233,075	233,075	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 7,590,504	\$ 7,621,083	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 8,388,861	\$ 8,419,440	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 271,445	\$ 271,445	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	128,671	128,671	29
30	Accrued Salaries Payable	352,323	352,323	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,759	26,759	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See attached Schedule 17A	2,175,004	2,175,004	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,954,202	\$ 2,954,202	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,640,000	4,640,000	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 4,640,000	\$ 4,640,000	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 7,594,202	\$ 7,594,202	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 794,659	\$ 825,238	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 8,388,861	\$ 8,419,440	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Pinecrest Manor  
Provider # 0012765  
6/30/2003

**Schedule 17A**

	<u>Operating</u>	<u>After Consolidation</u>
--	------------------	--------------------------------

Schedule XV - Line 9 Other Current Assets

Benefits Bank Account	2,740	2,740
Employee A/R	996	996
Benefits Bank	3,608	3,608
Miscellaneous Benefits	44	44
	<u>7,388</u>	<u>7,388</u>

Schedule XV - Line 23 Other Assets

Unamortized Bond Costs	191,845	191,845
Unamortized Line of Credit Fee	41,230	41,230
	<u>233,075</u>	<u>233,075</u>

Schedule XV - Line 36 Other Current Liabilities

Due to Related Party	355,000	355,000
Bank Overdraft	1,782,125	1,782,125
Restricted Funds Account	5,632	5,632
Founders Escrow	5,500	5,500
Other	26,747	26,747
	<u>2,175,004</u>	<u>2,175,004</u>

**See Accountants' Compilation Report**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,340,710	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,340,710	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(720,992)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (720,992)	17
	<b>B. Transfers (Itemize):</b>		
18	Interfund Transfer	174,941	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 174,941	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 794,659	24 *

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,955,754	1
2	Discounts and Allowances for all Levels	(1,360,040)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,595,714	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	420,056	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 420,056	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,529	13
14	Non-Patient Meals	19,230	14
15	Telephone, Television and Radio	491	15
16	Rental of Facility Space		16
17	Sale of Drugs	66,783	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,713	19
20	Radiology and X-Ray	1,500	20
21	Other Medical Services	69,334	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 163,580	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	26,731	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 26,731	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Attached Schedule 19A</b>	408,119	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 408,119	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,614,200	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,604,514	31
32	Health Care	3,536,030	32
33	General Administration	1,376,054	33
	<b>B. Capital Expense</b>		
34	Ownership	510,119	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	229,814	35
36	Provider Participation Fee	78,661	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,335,192	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(720,992)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (720,992)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

**Pinecrest Manor**  
**Provider # 0012765**  
**6/30/2003**

**Schedule 19A**

Schedule XVII - Line 28 Other Revenue

Pinecrest Village Management Fee	384,444
Pinecrest Village Meals	11,307
Pinecrest Village Transportation	272
Maintenance Services	50
Service Supplies	591
Vending Machine Income	10,340
Miscellaneous Income	1,115
Total	<u><u>408,119</u></u>

**See Accountants' Compilation Report**

Facility Name & ID Number **Pinecrest Manor**# **0012765**Report Period Beginning: **07/01/02**Ending: **6/30/03**

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,196	2,423	\$ 54,570	\$ 22.52	1
2	Assistant Director of Nursing	1,726	1,904	42,876	22.52	2
3	Registered Nurses	17,705	19,459	409,388	21.04	3
4	Licensed Practical Nurses	34,477	37,218	637,714	17.13	4
5	Nurse Aides & Orderlies	129,842	141,808	1,550,269	10.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,319	12,446	128,810	10.35	10
11	Social Service Workers	4,778	5,576	82,531	14.80	11
12	Dietician					12
13	Food Service Supervisor	2,470	2,949	45,317	15.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,710	13,685	106,546	7.79	15
16	Dishwashers	31,136	33,329	219,103	6.57	16
17	Maintenance Workers	10,576	11,875	175,358	14.77	17
18	Housekeepers	22,213	24,028	166,337	6.92	18
19	Laundry	12,586	13,621	112,188	8.24	19
20	Administrator	1,856	2,080	67,446	32.43	20
21	Assistant Administrator					21
22	Other Administrative	12,950	14,456	221,631	15.33	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,867	2,119	27,072	12.78	31
32	Other Health Care(specify)					32
33	Other(specify) <b>Development</b>	3,695	4,298	75,008	17.45	33
34	TOTAL (lines 1 - 33)	314,102	343,274	\$ 4,122,164 *	\$ 12.01	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	17,769	L9, C3	36
37	Medical Records Consultant	Monthly	300	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,378	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	\$ 20,447		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	393	\$ 16,113	L10, C3	50
51	Licensed Practical Nurses	1,763	63,921	L10, C3	51
52	Nurse Aides	3,813	71,588	L10, C3	52
53	TOTAL (lines 50 - 52)	5,969	\$ 151,622		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number    **Pinecrest Manor**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

#   0012765

Report Period Beginning:    07/01/02

Page 21

Ending:    6/30/03

<b>A. Administrative Salaries</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 20%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Vernon Showalter</td> <td>Administrator</td> <td>0%</td> <td style="text-align: right;">67,446</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 67,446</td> </tr> </tbody> </table>				Name	Function	Ownership %	Amount	Vernon Showalter	Administrator	0%	67,446																	TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,446	<b>D. Employee Benefits and Payroll Taxes</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr><td>Workers' Compensation Insurance</td><td style="text-align: right;">\$ 179,062</td></tr> <tr><td>Unemployment Compensation Insurance</td><td> </td></tr> <tr><td>FICA Taxes</td><td style="text-align: right;">281,341</td></tr> <tr><td>Employee Health Insurance</td><td style="text-align: right;">213,239</td></tr> <tr><td>Employee Meals</td><td> </td></tr> <tr><td>Illinois Municipal Retirement Fund (IMRF)*</td><td> </td></tr> <tr><td>Employer Pension Contributions</td><td style="text-align: right;">71,820</td></tr> <tr><td>Employee Physicals</td><td style="text-align: right;">2,415</td></tr> <tr><td>Employee Goodwill</td><td style="text-align: right;">4,941</td></tr> <tr><td>Employee Dental Insurance</td><td style="text-align: right;">5,337</td></tr> <tr><td>Other Employee Benefits</td><td style="text-align: right;">17,528</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td style="text-align: right;">\$ 775,683</td> </tr> </tbody> </table>				Description	Amount	Workers' Compensation Insurance	\$ 179,062	Unemployment Compensation Insurance		FICA Taxes	281,341	Employee Health Insurance	213,239	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Employer Pension Contributions	71,820	Employee Physicals	2,415	Employee Goodwill	4,941	Employee Dental Insurance	5,337	Other Employee Benefits	17,528					TOTAL (agree to Schedule V, line 22, col.8)	\$ 775,683	<b>F. Dues, Fees, Subscriptions and Promotions</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr><td>IDPH License Fee</td><td style="text-align: right;">\$  </td></tr> <tr><td>Advertising: Employee Recruitment</td><td style="text-align: right;">2,436</td></tr> <tr><td>Health Care Worker Background Check (Indicate # of checks performed _____)</td><td> </td></tr> <tr><td>Life Services Network of Illinois</td><td style="text-align: right;">7,336</td></tr> <tr><td>Miscellaneous Subscriptions</td><td style="text-align: right;">3,771</td></tr> <tr><td>Miscellaneous Dues</td><td style="text-align: right;">2,021</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Less: Public Relations Expense ( _____ )</td><td> </td></tr> <tr><td>Non-allowable advertising ( _____ )</td><td> </td></tr> <tr><td>Yellow page advertising ( _____ )</td><td> </td></tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td style="text-align: right;">\$ 15,564</td> </tr> </tbody> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment	2,436	Health Care Worker Background Check (Indicate # of checks performed _____)		Life Services Network of Illinois	7,336	Miscellaneous Subscriptions	3,771	Miscellaneous Dues	2,021							Less: Public Relations Expense ( _____ )		Non-allowable advertising ( _____ )		Yellow page advertising ( _____ )		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,564
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<b>B. Administrative - Other</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Description</th> <th style="width: 30%;">Amount</th> </tr> </thead> <tbody> <tr><td>N/A</td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)</td> <td style="text-align: right;">\$  </td> </tr> </tbody> </table>				Description	Amount	N/A						TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Description</th> <th style="width: 10%;">Line #</th> <th style="width: 50%;">Amount</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td>N/A</td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <td>TOTAL</td> <td> </td> <td style="text-align: right;">\$  </td> </tr> </tbody> </table>				Description	Line #	Amount							N/A																								TOTAL		\$	<b>G. Schedule of Travel and Seminar**</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr><td>Out-of-State Travel</td><td style="text-align: right;">\$  </td></tr> <tr><td> </td><td> </td></tr> <tr><td>In-State Travel</td><td style="text-align: right;">1,640</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Seminar Expense</td><td style="text-align: right;">6,326</td></tr> <tr><td>See Attached Detail</td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Entertainment Expense ( _____ )</td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Sch. V, line 24, col. 8)</td> <td style="text-align: right;">\$ 7,966</td> </tr> </tbody> </table>				Description	Amount	Out-of-State Travel	\$			In-State Travel	1,640					Seminar Expense	6,326	See Attached Detail				Entertainment Expense ( _____ )				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 7,966																
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\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Pinecrest Manor**  
**Provider #: 0012765**  
**07/01/02 to 6/30/03**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

Total (agree to Schedule V, line 19, column 3)	76,190
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Out of period Legal fees	(303)
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Total (agree to Schedule V, line 19, column 8)	<u>75,887</u>
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**See Accountants' Compilation Report**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

(Continued from Page 1)													
1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4								N/A					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pinecrest Manor

STATE OF ILLINOIS

# 0012765

Report Period Beginning:

07/01/02

Ending:

Page 23

6/30/03

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network of Illinois; \$ 7,336
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7.5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,500 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 78,661  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 19,230
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Altschuler, Melvoin & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

## RECONCILIATION REPORT

Pinecrest Manor

12:55 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-554,736	equal to	-554,736	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	136,894	equal to	136,894	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	385,627	equal to	385,627	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B. + C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	4,910	equal to	4,910	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	278,728	equal to	278,728	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	80,206	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,604,514	equal to	1,604,514	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,536,030	equal to	3,536,030	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,376,054	equal to	1,376,054	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	510,119	equal to	510,119	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	229,814	equal to	229,814	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	78,661	equal to	78,661	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,721,889	equal to	2,721,889	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	128,810	equal to	128,810	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	82,531	equal to	82,531	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	370,966	equal to	370,966	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	175,358	equal to	175,358	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	166,337	equal to	166,337	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	112,188	equal to	112,188	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	289,077	equal to	67,446	221,631	FAILED	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to	221,631	-221,631	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,122,164	equal to	4,122,164	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	3,661	-3,661	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	17,769	< or = to	17,769	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	151,922	< or = to	195,685	-43,763	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,378	< or = to	2,378	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	474	-474	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	67,446	equal to	67,446	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	76,190	equal to	76,190	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	775,683	equal to	775,683	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	15,564	equal to	15,564	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	7,966	equal to	7,966	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	78,661	equal to	78,661	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	-49,216	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,690	equal to	2,690	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-394,444	equal to	-394,444	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	4,768,671	equal to	4,768,671	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	20,626	equal to	20,626	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	9,447,057	equal to	9,447,057	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,565,438	equal to	1,565,438	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,007,863	equal to	4,007,863	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	794,659	equal to	794,659	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-720,992	equal to	-720,992	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	8,388,861	equal to	8,388,861	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Core Center Expenses	YOU MUST CHECK THE SUPPORT CLASS. That's 6,000 TO THE COST SUPPORT				G-22-PSA
File number	Name	Person Type			
Cost report period	From	to	to	Base Number	
Enter an 8-0000 facility, enter a 1 to 6	01/01/2000	12/31/2000	47,318 Pts of occupancy	90,225	
Contracted last day	01/01/2000				
Enter Core Unit Support/Type	6				
Card Services Salary/Wage	600,000 Card 1, Line 6 - (check off)				
Card Admin Salary/Wage	200,000 Card 1, Line 28 - (check off)				
Total Salary Wage	4,000 100 Card 1, Line 40 - (check off)				
Employee Benefits	170,000 Card 1, Line 32 - (check off)				
Total General Services	1,000,000 Card 1, Line 8 - (check off)				
Total General Admin	1,000,000 Card 1, Line 28 - (check off)				

[illegible][illegible][illegible][illegible][illegible]

<b>Charge Party Name</b> Charge and Proration Facility Name Address Phone No.	<b>YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LIMITED TO THE COST OF DEBT INTEREST</b> 11/06/06 COSTS LIMITED ON INDEX 13 THRU 155 AT END AT CEN (D)			12/05/25 PM
10000000 10000000 10000000 10000000	1 1 1 1	1 1 1 1	1 1 1 1	10000000 10000000 10000000 10000000
IF 10/25/12, these facilities have been continuously rented from an unrelated party since prior to January 1, 1979 (Y or N) or since the first day of operation for facilities constructed since January 1, 1979?	N			
<b>Cost Report Pct</b> Start End	01/01/00 12/31/00 01/01/00	100 Percent 100 Percent Capital Days	47.310 47.310 47.310	
1989 Property Tax COST:	(Actual dollar amount 1989 basis)			
1991 Property Tax RATE:	(Reflected dollar amount divided by 1991 rental price)			
FY 1991 Capital Rate:	(State loan 1991)			

**CAPITAL CALCULATIONS**

**A. Determine the base year for your building from Work Table A**

**B. Determine the Building Specific historical cost per bed:**

- 1. Work Table A, Line 24, Column (B)
- 2. Total licensed beds from card report Page 2, Line 7, column 3
- 3. Line 1 divided by Line 2
- 4. Roundup conversion integer from Table 2
- 5. Building specific historical Cost per bed (Line 3 \* Line 4, round to even \$)

**C. Obtain the Uniform Building Value from Table 1**

**D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5**

- 1. Building specific historical cost from Line B5
- 2. Uniform building value from Line C
- 3. Add Lines 1 and 2

Calculation Columns	
1000	1
	2
\$44,7057	3
143	4
\$68,083	5
+ 26	6
\$3309	7
	8
28832	9
	10
	11
	12
	13
	14
\$3203	15
28832	16
111862	17

WORK TABLE A				
	Year Acquired	Cost	Columns (A)-(I)	Lined Page
	Last 2 digits only			
1	03	1248321	7804622	12
2	04	13640	87290	12
3	05	600	26000	12
4	06	67603	4437195	12
5	07	43345	3771915	12
6	08	54715	3558775	12
7	08	3231	222930	12
8	71	9871	700841	12
9	73	4139	324968	12
10	73	567	41391	12
11	74	130481	9655594	12
12	75	17918	1343850	12
13	75	22463	1708708	12
14	77	12308	487716	12
15	78	1354	150512	12
16	79	15865	858915	12
17	80	4121	486860	12

Year Acquired (A)	Cost (B)	Columns (A) * (B)	Linked Page
Last 2-epoch only			
87	102	1850	188700
88	102	4542	461204
89	102	96350	9874864
100	103	162555	1674265
101	103	184791	19020383
102	103	37651	6666853
103	0	0	0
104	0	0	0
105	0	0	0
106	0	0	0
107	0	0	0
108	0	0	0
109	0	0	0
110	0	0	0
111	0	0	0
112	0	0	0
113	0	0	0

Year	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Uniform Building Value	4754	5346	6683	7817	9051	10385	11919	12754	13668	15222	16456	17561	18605	20139	21983
1970-79	2760	4896	6020	7155	8281	9415	10549	11683	12804	13934	15064	16194	17324	18453	19583

Year	2 & 3	4 & 5	6
1960	0.25	0.08	0.29
1961	5.67	5.52	5.60
1962	5.07	5.52	5.60
1963	5.47	5.52	5.60
1964	5.67	5.52	5.60
1965	5.07	5.52	5.60
1966	5.36	5.23	5.35
1967	5.1	4.97	5.03
1968	4.85	4.71	4.83
1969	4.61	4.48	4.59
1970	4.38	4.25	4.38
1971	4.01	3.89	4.00
1972	3.64	3.53	3.63
1973	3.36	3.26	3.33
1974	3.08	3	3.09

Year	MSA	Ratio
1	1	1.00000
2	2	1.0396
3	3	1.0333
4	4	1.0303
5	5	1.03763
6	6	1.02968
7	7	1.02594
8	8	1.02813
9	9	1.01315
10	10	1.0015
11	11	1.00027

Column
1
1
2
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1
3

63	68748	6457394	12	119	0	0	0	1000	1987	20084	22973	1977	2.07	2.48	2.35	2.68
64	68748	6457394	12	117	0	0	0	1000	1988	20024	24132	1978	2.07	2.39	2.38	2.49
65	26902	2414175	12	119	0	0	0	1000	2009	27094	29332	1979	2.18	3.12	2.91	2.38
66	12199	1025864	12	119	0	0	0	1000	1989	20594	29332	1980	1.98	1.92	2.35	2.38
67	12199	1025864	12	119	0	0	0	1000	1990	20594	29332	1981	1.98	1.92	2.35	2.38
68	77	18000	1001000	12	121	0	0	1000	1982	20397	28602	1982	1.87	1.83	1.75	1.76
69	42008	2022460	12	122	0	0	0	1000	1993	20511	29332	1983	1.84	1.5	1.27	1.83
70	81	2140	174000	12	123	0	0	1000	1994	23774	20061	1984	1.51	1.47	1.55	1.56
71	16002	2000000	12	124	0	0	0	1000	1995	24010	20111	1985	1.58	1.42	1.46	1.48
72	199	170000	12	127	0	0	0	1000	1997	25428	24471	1987	1.44	1.4	1.44	1.62
73	199	170000	12	127	0	0	0	1000	1998	25671	25400	1988	1.4	1.38	1.38	1.49
74	2700102	27523079	12	128	0	0	0	1000	1999	26927	26520	1989	1.35	1.33	1.35	1.41
75	400	400	12	128	0	0	0	1000	2000	41143	37660	1990	1.29	1.26	1.25	1.27
76	87	37000	3860000	12	131	0	0	1000	1990	1.26	1.26	1.27	1.28			
77	14973	1025864	12	134	0	0	0	1000	1991	1.29	1.26	1.25	1.27			
78	81	10790	90400	12	133	0	0	1000	1994	1.22	1.22	1.22	1.25	1.19		
79	14973	1025864	12	134	0	0	0	1000	1995	1.22	1.22	1.22	1.25	1.17		
80	82	5049	240100	12	135	0	0	1000	1998	1.12	1.11	1.12	1.12			
81	2071	200000	12	135	0	0	0	1000	1997	1.11	1.08	1.17	1.11			
82	2071	200000	12	135	0	0	0	1000	1998	1.11	1.08	1.17	1.11			
83	2494	240007	12	138	0	0	0	1000	1999	1.04	1.04	1.04	1.04	1.04		
84	24949	2400000	12	138	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03		
85	4405	421000	12	140	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03		
86	441	40774	12	140	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03		
87	14178	1320792	12	143	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03		
88	135	100000	12	144	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03		
89	2016	241000	12	145	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03		
90	4902	470000	12	146	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03		
91	1306	134445	12	146	0	0	0	1000	2000	1.03	1.03	1.03	1.03	1.03	</	

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	370,966	21,131	3,661	395,758	0	395,758	-63,558	332,200
2. Food Purchase	0	384,608	0	384,608	0	384,608	-105,763	278,845
3. Housekeeping	166,337	39,369	5,655	211,361	0	211,361	-31,356	180,005
4. Laundry	112,188	15,979	0	128,167	0	128,167	-4,215	123,952
5. Heat and Other Utilities	0	0	196,230	196,230	0	196,230	0	196,230
6. Maintenance	175,358	11,247	101,785	288,390	0	288,390	-53,431	234,959
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	824,849	472,334	307,331	1,604,514	0	1,604,514	-258,323	1,346,191
9. Medical Director	0	0	17,769	17,769	0	17,769	0	17,769
10. Nursing & Medical Records	2,721,889	90,400	195,685	3,007,974	0	3,007,974	-17,662	2,990,312
10a. Therapy	0	0	278,728	278,728	0	278,728	0	278,728
11. Activities	128,810	12,456	2,378	143,644	0	143,644	-1,563	142,081
12. Social Services	82,531	0	474	83,005	0	83,005	0	83,005
13. Nurse Aide Training	0	0	4,910	4,910	0	4,910	0	4,910
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,933,230	102,856	499,944	3,536,030	0	3,536,030	-19,225	3,516,805
17. Administrative	67,446	0	0	67,446	0	67,446	0	67,446
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	76,190	76,190	0	76,190	-303	75,887
20. Fees, Subscriptions & Promotion	0	0	15,564	15,564	0	15,564	0	15,564
21. Clerical & General Office	221,631	30,855	52,272	304,758	0	304,758	-90,253	214,505
22. Employee Benefits & Payroll	0	0	824,899	824,899	0	824,899	-49,216	775,683
23. Inservice Training & Education	0	0	1,691	1,691	0	1,691	0	1,691
24. Travel and Seminar	0	0	8,176	8,176	0	8,176	-210	7,966
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	77,330	77,330	0	77,330	0	77,330
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	289,077	30,855	1,056,122	1,376,054	0	1,376,054	-139,982	1,236,072
29. Total General Administrative	4,047,156	606,045	1,863,397	6,516,598	0	6,516,598	-417,530	6,099,068
30. Depreciation	0	0	346,494	346,494	0	346,494	39,133	385,627
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	163,625	163,625	0	163,625	-26,731	136,894
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	510,119	510,119	0	510,119	12,402	522,521
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	80,206	0	80,206	0	80,206	0	80,206
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	78,661	78,661	0	78,661	0	78,661
43. Other (specify):*	75,008	931	73,669	149,608	0	149,608	-149,608	0
44. Total Special Cost Ce	75,008	81,137	152,330	308,475	0	308,475	-149,608	158,867
45. Grand Total	4,122,164	687,182	2,525,846	7,335,192	0	7,335,192	-554,736	6,780,456

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	29,574	29,574
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	621,536	621,536
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	76,817	76,817
7. Other Prepaid Expenses	63,042	63,042
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	7,388	7,388
10. Total current assets	798,357	798,357
LONG TERM ASSETS		
11. Long-Term Notes Receivable	362,750	362,750
12. Long-Term Investments	0	0
13. Land	20,626	20,626
14. Buildings, at Historical Cost	8,936,406	9,447,057
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,863,703	1,565,438
17. Accumulated Depreciation (book methods)	-3,826,056	-4,007,863
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	233,075	233,075
24. Total Long-Term Assets	7,590,504	7,621,083
25. Total Assets	8,388,861	8,419,440
CURRENT LIABILITIES		
26. Accounts Payable	271,445	271,445
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	128,671	128,671
30. Accrued Salaries Payable	352,323	352,323
31. Accrued Taxes Payable	26,759	26,759
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,175,004	2,175,004
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,954,202	2,954,202
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	4,640,000	4,640,000
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	4,640,000	4,640,000
46. Total Liabilities	7,594,202	7,594,202
47. Total Equity	794,659	825,238
48. Total Liabilities and Equity	8,388,861	8,419,440

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,955,754
2. Discounts and Allowances for all Levels	-1,360,040
Subtotal - Inpatient Care	5,595,714
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	420,056
7. Oxygen	0
Subtotal - Ancillary Revenue	420,056
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	2,529
14. Non-Patient Meals	19,230
15. Telephone, Television, and Radio	491
16. Rental of Facility Space	0
17. Sale of Drugs	66,783
18. Sale of Supplies to Non-Patients	0
19. Laboratory	3,713
20. Radiology and X-Ray	1,500
21. Other Medical Services	69,334
22. Laundry	0
Subtotal - Other Operating Revenue	163,580
24. Contributions	0
25. Interest and Other Investments Income	26,731
Subtotal - Non-Operating Revenue	26,731
27. Other Revenue (specify):	408,119
28. Other Revenue (specify):	0
Subtotal - Other Revenue	408,119
30. Total Revenue	6,614,200
31. General Services	1,604,514
32. Health Care	3,535,730
33. General Administration	1,376,354
34. Ownership	510,119
35. Special Cost Centers	229,814
35. Provider Participation Fee	78,661
37. Other	0
40. Total Expenses	7,335,192
41. Income Before Income Taxes	-720,992
42. Income Taxes	0
43. Net Income or Loss for the Year	-720,992

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23 Provider Participation fee is linked from page 4